Camp Fire
Camp Toccoa

Summer 2024
Health Packet

Dear Parent/Guardian,

We look forward to getting to know you better and working with you to ensure your camper has a safe and successful stay at Camp Toccoa. Please review and complete all documents included within this packet.

All campers must have a new health form each year. Note that the medical form (page 6) requires a signature by a licensed medical care provider. Include a copy of the camper's insurance card (front and back) along with a current immunization record.

If your camper will be taking medication while at Camp Toccoa, over the counter or prescribed, complete a Medication Administration Record (page 8 in this packet) for EACH SESSION the camper is attending. (i.e., If your camper is attending 2 sessions, you must complete 2 forms). If your camper has an epi pen or inhaler, please complete the Epi Pen/Inhaler section on page 7.

Prescription medication must be brought to camp in its original container containing only the dosage required for your camper's stay. Medication will be counted by a member of the health team at check in. Do not send over-the-counter medication or vitamins with the exception of Melatonin or daily allergy medication which must be in the original container and only containing the required dosage for the campers stay.

Camp Toccoa cannot accept medication that is not in the original prescription container, any amount over the exact dosage for the camper's stay, over the counter medication that is not Melatonin or daily allergy medication, or any medication that is not accompanied by the Medication Administration Record. Medications, prescribed or over the counter, are not to be stored in camper's luggage. If medication is found in your camper's luggage, the parent/guardian will be notified, and the medication will not be administered to the camper.

Completed forms with original signatures must be mailed to Camp Toccoa and postmarked no later than 3 weeks before your camper's arrival at camp. Please keep a copy of your completed health form and bring it with you when you drop off your camper. Campers without a health form bearing the signature of a medical professional will not be permitted to stay at camp. No refunds will be issued for campers who cannot stay due to incomplete health forms.

Mail completed forms to:
Camp Toccoa / Medical Form
92 Camp Toccoa Drive
Toccoa, GA 30577

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Camp Fire Georgia / Camp Toccoa
Camper Medical and Health History
2024

Attending Camp Session(s)

1 2 3 4 5 6

CIT LIT Staff

The information on this form is not part of the camper or staff acceptance process but is gathered to assist us in identifying appropriate care. Any changes to this form should be provided to the camp health personnel upon the participant's arrival at camp. Provide complete information so that the camp can be aware of your camper's needs.

A NEW MEDICAL FORM IS REQUIRED EACH YEAR.
PAGE 6 MUST BE COMPLETED BY A LICENSED MEDICAL PROVIDER

Last Name: _____

First Name: _____

PARTICIPANT INFORMATION

Please Print

Participant Name: _____
Last First Middle

Home Address: _____
Street Address City State Zip

Birth Date _____/____/_____ Age at Camp_____ Gender: Male Female

Parent/Guardian Name: _____ Phone: _____

Home Address: _____
(If different from above) Street Address City State Zip

Second Parent/Guardian Name: _____ Phone: _____

If neither parent/guardian is available in emergency, notify:_____

Relationship to camper: _____ Phone: _____

Home Address: _____
Street Address City State Zip

2nd Emergency Contact: _____

Relationship to camper: _____ Phone: _____

Home Address: _____
Street Address City State Zip

INSURANCE INFORMATION

Is the participant covered by family medical/hospital insurance? Yes ☐ No ☐
If no, sign and date the **waiver** on page 5 of this form.
If yes, please indicate carrier or plan name: _____ Group # _____
Date of birth of the primary card holder: _____/_____/_____

A photo copy of the front and back of the health insurance card must be attached to this form.

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Office (706) 886-2457

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ALLERGIES (lists all known allergies, attach additional sheet if needed)

Allergies	Type of reaction	Estimated Date of last reaction
_____	_____	_____
_____	_____	_____
_____	_____	_____

MEDICATIONS BEING TAKEN

List **ALL** medications (including over the counter) or non-prescription drugs) taken routinely. Bring enough medication to last the entire time at camp. All medication must be in the original packing/bottle that identifies the prescribing physician, the name of the medication, the dosage and the frequency of administration.

This person takes NO medication on a routine basis OR this person takes medications as follows:

Medication #1 _____ Dosage _____ Time of day taken _____
Reason for taking: _____

Medication #2 _____ Dosage _____ Time of day taken _____
Reason for taking: _____

Medication #3 _____ Dosage _____ Time of day taken _____
Reason for taking: _____

Medication #4 _____ Dosage _____ Time of day taken _____
Reason for taking: _____

Attach additional pages for more medications. Also, please identify any medications taken during the school year that the participant does not need at camp _____

The following non-prescription medications are available to be given by the camp nurse and are used on an as needed basis to manage illness and injury.

Circle medications that are *okay* to give to the camper

Acetaminophen (Tylenol)	Ibuprofen	Cough medication
Benadryl	Cough drops	Calamine lotion
Hydrocortisone cream	Topical antibiotic cream	Anti-nausea
Solarcaine (Aloe)	Bismuth subsalicylate (Pepto-Bismo)	

RESTRICTIONS (The following restrictions apply to this individual)

Does not eat: ☐ Red Meat ☐ Pork ☐ Dairy Products ☐ Poultry
☐ Seafood ☐ Egg Other _____ _____

Last Name: _____

First Name: _____

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Last Name: _____

First Name: _____

GENERAL QUESTIONS

Has/does the participant:	Yes	No
Had any recent injury, illness or infectious disease?		
Have a chronic or recurring illness/condition?		
Ever been hospitalized?		
Ever had surgery?		
Have frequent headaches?		
Ever had a head injury?		
Ever been knocked unconscious?		
Wear glasses, contacts or protective lenses?		
Ever had frequent ear infections?		
Ever passed out during or after exercise?		
Ever been dizzy during or after exercise?		
Ever had seizures?		
Ever had chest pains during or after exercise?		
Ever had high blood pressure?		
Ever been diagnosed with a heart murmur?		
Ever had problems with joints (e.g. knees)?		
Ever had back problems?		
Have ear tubes?		
Have an orthodontic appliance at camp?		
Have any skin problems? (e.g. itching, rash?)		
Have diabetes?		
Have asthma?		
Had mononucleosis in the last 12 months?		
Had problems with diarrhea/constipation?		
Have problems with sleep-walking?		
If female, have abnormal menstrual history?		
Have a history of bed wetting?		
Ever had an eating disorder?		
Ever had emotional difficulties in which professional help was sought?		
Had a significant life event that continues to after the camper's life? Abuse, death, divorce, etc..		

Please explain "yes" answers: _____

_____

_____

Use this space to provide any additional information about the participant's behavior and physical, emotional, or mental health about which the camp should be aware: _____

_____

_____

_____

_____

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Last Name: _____

First Name: _____

IMMUNIZATIONS:

Which of the following has the camper had?

____ Measles
____ Chicken Pox
____ German measles
____ Mumps
____ Hepatitis A
____ Hepatitis B
____ Hepatitis C

TB Mantoux test
Date of last test: _____
Result: ___ Positive ____ Negative

Please give dates of all immunizations:

Vaccine	M/Y	M/Y	M/Y	M/Y	M/Y	M/Y
DTP						
TD Tetanus/diphtheria						
Tetanus						
Polio					X	X
MMR			X	X	X	X
Or Measles			X	X	X	X
Or Mumps			X	X	X	X
Or Rubella			X	X	X	X
Hemophilus influenza B					X	X
Hepatitis B				X	X	X
Varicella (chicken pox)			X	X	X	X
COVID / Boosters						

If your camper has not been fully immunized, please sign the following statement:

I understand and accept the risks to my child from not being fully immunized.

Signature of parent or guardian: _____ Date: _____

HEALTH CARE PROVIDERS:

Name of camper's primary doctor: _____ Phone: _____

Name of camper's dentist: _____ Phone: _____

Name of camper's orthodontist: _____ Phone:_____

Have we forgotten anything? In the space below please provide any additional information about the camper's health you think is important or that may affect the camper's ability to fully participate in the camp program. Attach another page if needed.

_____

_____

_____

_____

_____

_____

_____

_____

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PARENT/GUARDIAN AUTHORIZATIONS:

This health history is correct and complete as far as I know, and the person herein described has permission to engage in all camp activities except as noted.

I hereby give permission to the camp to provide routine health care, administer prescribed medications and seek emergency medical treatment including x-rays or routine tests. I agree to the release of any records necessary for treatment, referral, billing or insurance purposes. I give permission to the camp to arrange necessary related transportation for me/my child. In the event I cannot be reached in an emergency, I hereby give permission to the physician selected by the camp to secure and administer treatment, including hospitalization, for the person named above. The completed form may be photocopied for trips out of camp.

Name of Camper: _____

Signature of parent or guardian: _____

Printed name _____ Date_____

WAIVER FOR CAMPERS WITHOUT MEDICAL INSURANCE

Camp Fire is NOT responsible for campers' medical bills to clinics, hospitals, or other providers or pharmacists.

I accept financial responsibility for all medical/medication costs for my child. If my child becomes ill, I understand that I will be called to pick up my child so that I can take them directly to my preferred health care provider. I understand that, in the case of an emergency, Camp Toccoa will follow established procedures and I will be notified and will be responsible for any related costs.

Name of Camper: _____

Signature of parent or guardian: _____

Printed name _____ Date_____

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Camp Fire Georgia / Camp Fire Camp Toccoa
Camper Medical and Health History

Participant Name: _____

Last First Middle

Home Address: _____

Street Address City State Zip

Birth Date _____/____/_____ Age at Camp_____ Gender: Male Female

Physical exam done today: _____ Yes _____ No If no, date of last physical:

Month/Day/Year

A physical exam must have been performed within 12 months of the camper attending Camp Toccoa.

Weight _____ lbs Height _____ ft _____ in Blood Pressure _____/_____

ALLERGIES _____ **No known allergies**

To foods (list): _____
To medications (list):_____
To the environment (insect stings, etc):_____
Other allergies (list):_____
Describe previous reaction:

DIETARY RESTRICTIONS (The following restrictions apply to this individual)
Does not eat: ☐ Red Meat ☐ Pork ☐ Dairy Products ☐ Poultry ☐ Seafood ☐ Egg Other _____

The camper is undergoing treatment at this time for the following conditions: (describe below)

MEDICATION _____ **No medications take daily** _____ **will take the following prescribed medications while at camp**

Medication #1 _____ Dosage _____ Time of day taken _____
Reason for taking: _____

Medication #2 _____ Dosage _____ Time of day taken _____
Reason for taking: _____

Medication #3 _____ Dosage _____ Time of day taken _____
Reason for taking: _____

Attach additional pages for more medications. Also, please identify any medications taken during the school year that the participant does not need at camp _____.

Do you feel that the camper will require limitations or restrictions to activity while at camp? _____ Yes _____ No
If you answered "yes" to the questions above, what do you recommend? Describe below, attach additional sheet if needed.

"I have reviewed the Camper Medical and Health History form and have discussed the camp program with the campers parent(s)/guardian(s). It is my opinion that the camper is physically and emotionally fit to participate in an active camp program (except as noted above.)"

Name of licensed medical provider (please print): _____
Signature: _____ Title:_____
Office Address:_____
Telephone: _____ Date:_____

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Office (706) 886-2457

Camp Fire
Camp Toccoa

Camper Name: _____
Unit: _____ Cabin #: _____
Counselor: _____
Session #_____

Contemplate this portion if your camper has an Epi Pen/ Inhaler

Circle One: **Epi Pen (Allergy to: _____)**

Inhaler

We request that the child named above be permitted to: (choose one) 1) carry his/her own Epi Pen/Inhaler, or 2) store the medication on-site under the supervision of the camp medical designee.

I direct my child's medication to be stored: _____.
CHOOSE ONE OF THE OPTIONS FROM THE ABOVE PARAGRAPH

If you choose to permit your child to carry his/her medication you are agreeing that he/she has been instructed in the proper procedure of self-administration and is capable of carrying his/her own properly labeled Epi Pen / Inhaler in the original container. He/she understands the purpose, proper method, and the frequency of the use of this medication as prescribed my child's physician.

Parent/Guardian Signature: _____ Date: _____

Complete the next page if your camper will be taking ANY medication while at Camp Fire Camp Toccoa.

If your camper will be taking medication while at Camp Fire Camp Toccoa, over the counter or prescribed, the Medication Administration Record (next page) must be completed and returned for EACH SESSION the camper is attending.

Prescription medication must be sent in the original container containing only the dosage required for your campers stay. Controlled substances will be counted by the nursing staff or camp director at check in. Do not send over the counter medication or vitamins with the exception of Melatonin or daily allergy medication which must be in the original container and only containing the required dosage for the campers stay. Camp Fire Camp Toccoa cannot accept medication that is not in the original prescription contain, any amount over the exact dosage for the campers stay, over the counter medication that is not Melatonin or daily allergy medication, or any medication that is not accompanied by the Medication Administration Record. Medications, prescribed or over the counter, are not to be stored in camper's luggage. If medication, vitamins etc. is found in your camper's luggage, the parent/guardian will be notified, and the medication will not be administered to the camper.

On the table below please list your child's medication by name (using the name on the prescription), and the required dosage. Note that Camp Fire Camp Toccoa personnel can only administer the dosage as prescribed on the bottle. If your camper takes the same medication multiple times a day, it must be written in each time slot.

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Camp Fire
Camp Toccoa

Camper Name: _____
Unit: _____ Cabin #: _____
Counselor: _____
Session #_____

Camper Medication Administration Record

Medication will not be dispensed on the day/times of the grayed out boxes UNLESS your child is staying for changeover!

Breakfast Medication

Name of Medication / Dosage	Time Dispensed	Sun	Mon	Tue	Wed	Thurs	Fri	Sat
	BREAKFAST							
	BREAKFAST							
	BREAKFAST							
	BREAKFAST							

Lunch Medication

Name of Medication / Dosage	Time Dispensed	Sun	Mon	Tue	Wed	Thurs	Fri	Sat
	LUNCH							
	LUNCH							

Dinner Medication

Name of Medication / Dosage	Time Dispensed	Sun	Mon	Tue	Wed	Thurs	Fri	Sat
	DINNER							
	DINNER							
	DINNER							
	DINNER							

Bedtime Medication

Name of Medication / Dosage	Time dispensed	Sun	Mon	Tue	Wed	Thurs	Fri	Sat
	BEDTIME							
	BEDTIME							
	BEDTIME							
	BEDTIME							

Additional Comments: _____

_____

_____

Parent/Guardian Signature: _____ **Date:** _____

For Staff Use Only

Control Substance	Count In	Parent/ Guardian Initials	Staff Initials	Count Out	Nurse	Camp Director

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Camper Name: _____

Session # 1 2 3 4 5 6

2024 Camp Toccoa/Camp Owanyake

Camper and Parent Behavioral Agreement

(Camper is to initial next to each)

I, _____ (camper name) understand and agree to the following, which has been reviewed with me by my parent(s)/guardian:

_____ I am expected to be able to function well in group settings. Chronically disruptive and/or severe behavior may be grounds for dismissal from the program.

_____ Possession of any of the following could result in immediate dismissal from camp: drugs, alcohol, tobacco, firearms, explosives or any other weapon.

_____ Violent, inappropriate, or sexual behavior toward campers, staff, or any other individual will be grounds for dismissal.

_____ Camp Toccoa does not allow digital cameras, cell phones or any other recording devices. Participants may not upload pictures or videos taken while at Camp Fire Camp Toccoa to any website, blog or other social media site while on Camp Fire Camp Toccoa property.

_____ Participants who use blogs or personal web sites to harass, bully, or intimidate other campers or employees of Camp Toccoa while at camp will may be sent home or will not be allowed to participate in future or additional Camp Fire programs. Behaviors that constitute harassment and bullying include, but are not limited to, comments that are derogatory with respect to race, religion, gender, sexual orientation, color, or disability; sexually suggestive, humiliating, or demeaning comments; and threats to stalk, haze or physically injure another person. Blogs or personal sites used after the camp session concludes may not be allowed to participate in future programs, either for a limited period or permanently.

(continued on next page)

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Camper Name: _____

Session # 1 2 3 4 5 6

(Parent/guardian is to initial next to each)

I, _____ parent/guardian) understand and agree to the following:

_____ Camp Toccoa has provided a suggested packing list. Parent/guardians are responsible for ensuring that campers are prepared to participate in Camp Toccoa programs.

_____ It is the responsibility of the parent/guardian to ensure that campers do not have in their possession valuables, electronics, cell phones, digital cameras, cash or any other prohibited items.

_____ Camp Toccoa reserves the right to search camper's personal property, with camper present, for the wellbeing and safety of campers and staff. Examples may include, but are not limited to, suspicion of prohibited items, an effort to locate lost or misplaced items.

_____ All medical/behavior information that is essential for the safety and wellbeing of the campers and Camp T occoa staff will be disclosed to the Camp Toccoa nurse/health officer.

_____ Permission is given for the camper to be photographed and/or videoed by staff while participating in Camp Fire Camp Toccoa programs. Photos/videos may be published and used by Camp Fire for promotional purposes.

_____ I have reviewed this agreement with my camper to ensure that my child understands the behavioral agreement.

_____ I have read and agree to follow the policies and procedures outlined in the camper confirmation packet.

Camper Signature:

_____

Parent Signature:

_____

Date: _____

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